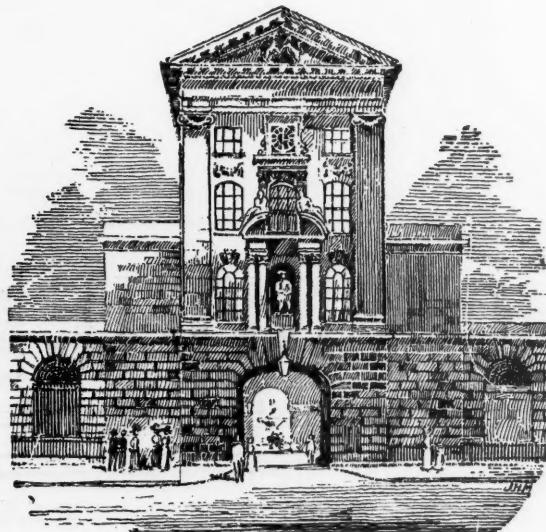


ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXXIII.—No. 1.

OCTOBER, 1925.

[PRICE NINEPENCE.]

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"Æquam memento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

JOURNAL.

VOL. XXXIII.—No. 1.]

OCTOBER 1ST, 1925.

PRICE NINEPENCE.

CALENDAR.

- Thurs., Oct. 1.—Old Students' Dinner in the Great Hall.
Fri., " 2.—Prof. Fraser and Prof. Gask on duty.
Sat., " 3.—Rugby Match v. Moseley. Away.
Mon., " 5.—Special Subject Lecture. Mr. Elmslie.
Tues., " 6.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Wed., " 7.—Clinical Surgery Lecture. Sir Holburt Waring.
Fri., " 9.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Clinical Medicine Lecture. Dr. Langdon Brown.
Sat., " 10.—Rugby Match v. Richmond. Away.
Mon., " 12.—Special Subject Lecture. Mr. Harmer.
Tues., " 13.—Sir Thomas Horder and Mr. Rawling on duty.
Wed., " 14.—Clinical Surgery Lecture. Mr. McAdam Eccles.
Fri., " 16.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.
Clinical Medicine Lecture. Dr. Morley Fletcher.
Sat., " 17.—Rugby Match v. Northampton. Away.
Mon., " 19.—Special Subject Lecture. Mr. Just.
Tues., " 20.—Prof. Fraser and Prof. Gask on duty.
Wed., " 21.—Clinical Surgery Lecture. Sir Holburt Waring.
Rugby Match v. Cambridge University. Home.
Last day for receiving matter for November issue of the Journal.
Fri., " 23.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
Clinical Medicine Lecture. Dr. Langdon Brown.
Sat., " 24.—Rugby Match v. R.M.A. Away.
Mon., " 26.—Special Subject Lecture. Mr. Harmer.
Tues., " 27.—Sir P. Horton-Smith Hartley and Mr. McAdam Eccles on duty.
Wed., " 28.—Clinical Surgery Lecture. Mr. McAdam Eccles.
Rugby Match v. Cardiff. Away.
Fri., " 30.—Sir Thomas Horder and Mr. Rawling on duty.
Clinical Medicine Lecture. Sir Thomas Horder.
Sat., " 31.—Rugby Match v. Old Leysians. Away.

EDITORIAL.

EVERY profession which is dear to the heart of its exponents tends to produce a specific series of metaphors. Merely to emphasize that a particular statement is correct a carpenter will say, " You have hit the nail on the head ; " a soccer forward will say, " You've scored," and possibly a signalman would say, " You are on the right line," and a jockey, " You've backed a winner." Surely no one can criticize a Hospital journal for discussing its " circulation." As for our fleshy temples, so for any literary effort, life depends upon circulation.

Recently we have been troubled by quite a few letters of this order :

" DEAR SIR,—Since leaving the Hospital after qualifying I have not received my copy of the JOURNAL. [Here follow a few remarks which modesty compels us to omit concerning the excellence of our periodical, its powerful linking with the hub of medical thought, etc., etc. It continues:] On commencing my medical studies my benevolent parent paid a large sum of money on my behalf as my subscription for life membership of the Students' Union. If I am a life member why am I not receiving my JOURNAL, for, contrary to metropolitan opinion, medical practitioners, even if resident in Blankshire, are still living ? "

We are desirous to clear up any little misunderstanding. The JOURNAL is supplied free of charge to all members of the Students' Union *until they are qualified*. On qualification all members are asked to become subscribers. No JOURNALS are posted to men who have not registered as subscribers, and the JOURNALS supplied on demand in the Cloak Room are for non-qualified men only. An exception is made to members of the Junior Staff, who have a right, during their term of office, to obtain copies free of charge.

We are naturally desirous continually to increase our circulation, and we hope that no men leaving the Hospital and going into practice will fail to become regular subscribers. We are convinced that the gain will be mutual.

* * *

At this time when there is widespread interest in the curriculum for nurses' training, we are pleased to record a new departure in the teaching of nursing at this Hospital.

Buildings have been equipped at King's Square for the accommodation and instruction of twelve probationers. This preliminary course will last for six weeks, and instruction will be given in anatomy, physiology, hygiene and cooking, as well as in the elementary practical points of nursing.

Miss Smith, better known to our readers as Sister Darker, has accepted the position of Sister-in-Charge. We feel sure that this innovation will raise still farther our high standard of nursing, and will considerably add to the joys and lessen the sorrows of the junior probationer when she starts work in the wards.

* * *

Men in blue overalls have been stealthily creeping round behind the beds throughout each block, tacking bunches of wire neatly against the walls. The hope of "wireless for every bed" is fast becoming a fact.

A large central valve set is being fixed in the basement under Casualty Ward, and the general receiving aerial will be over this block.

* * *

A most interesting fact has recently come to our notice.

In Tonypandy there is a Bart.'s doctor who is collecting money to instal an X-ray plant in the local hospital. Many of our readers, remembering their days of surgical dressing, will realize that a certain jibe will have to be moulded anew. For old times' sake we feel like opening a subscription list for this worthy object.

* * *

The reopening of the South Block of wards and the return of sisters to duty has seen several changes in ward staff. Miss Duke has left the gloomy confines of Casualty to be Sister Charity, Miss Smith, as mentioned above, has left Darker to become Sister-in-Charge of the Preliminary Training School, and Miss Stevenson has taken her place as Sister Darker. Miss Watkins

has been appointed Sister Casualty, and Miss Gray takes the post of Assistant Sister Theatres. We offer to them all our best wishes in their new spheres of work.

HUMOUR AND THE CONSULTANT:

I. THE DOCTOR.

(Concluded.)



HE doctor's parting words, said half to himself and half to me as he passed out of my room, had been: "And she is such a valuable cook." These same words rang in my ears as I went my "round," and they ceased not to echo when I resumed my consultations at home, so that for sheer peace of mind I wrote to him and apologized for the exigency which had interrupted our discussion of the health of his household and asked if the cook might be spared to come and see me. This done, my conscience gave me a little peace.

The enthusiasms of doctors for special views in pathology and for special lines of therapeutics often lead to situations that do not lack humour. I sometimes see a very intelligent patient under process of psycho-analysis by a doctor whose mental equipment is of the most limited kind, and whose knowledge of the world is far inferior to that of the person he is trying to help—a pathetic as well as a humorous sight. The obsession of "endocrine imbalance" may prevent a man from recognizing a glaring clinical picture. One such enthusiast brought me a patient and told me with great excitement that he felt sure she was suffering from an unusual mixture of endocrine defects, and he besought my help to unravel the various elements in the disturbed economy. He described the case, and left me wondering if I could possibly hope to throw light upon what appeared from his account to be a very complex problem. He initiated me into the mystery of several formulae which he had tried in vain; one of these contained no less than five different internal secretions. I professed myself puzzled and rang the bell for the patient. There walked slowly into the room such a typical case of myxoedema that not to "spot" it at sight would have "ploughed" a candidate at any final examination, and legitimately. The largest dose of thyroid in any of my friend's prescriptions had been $\frac{1}{16}$ of a grain.

I suppose we are all of us slaves to our particular theories and to the things we have been taught as "facts." A patient once came to me and said plaintively, "Do you know why my doctor won't give me bicarbonate of

soda for my indigestion?" I confessed that I did not, and I murmured something about its being quite a cheap remedy. He then showed me a prescription containing peroxide of magnesia, which, he said, his doctor told him was much superior to the soda, but it didn't relieve his pain, nor did it give him that comforting sensation of "getting rid of the wind." I changed the drug which was theoretically the better anti-acid for the one which, in practice, had produced the desired result. A grateful letter followed, with comments upon my skill. I have effected the same simple adjustment in the same doctor's formulae two or three times since, and each time with good results.

Young doctors starting in practice in the country sometimes find that their *flair* for surgery is not so popular as they imagined it would be when they were house-surgeons. "Are you doing much surgery here, Smith?" I once asked an old pupil of mine whom I met after a long interval; "I remember you were very keen on it." "No," said Smith, "not very much; you see one has to live amongst one's patients." Which reflection perhaps determined the conduct of another doctor who, before leaving a partnership in a certain district, "took a look round before retiring," and enucleated all the tonsils which he had previously guillotined.

I find the great majority of doctors receive my suggestions as to diagnosis with almost painful deference. Occasionally, however, they are resented. A friend of mine, an old hospital contemporary, was once indignant because I told him I thought a certain curious skin eruption in the case of a favourite patient of his was factitious. He was quite rude as he strode about my room. When his heat had cooled he asked me what conceivable reason I thought an extremely intelligent girl could have for making such a fool of herself. "I don't know," I said; "perhaps she is in love with her doctor," at which he angrily left the house. But he was a good fellow; he wrote and apologized twelve months afterwards, telling me my diagnosis was quite correct, both in regard to the nature of the eruption and the motive underlying it.

Not only are the majority of practitioners genuinely grateful for any effort at helping them, most of them are equally desirous of assisting the consultant, who stands a big risk of making a fool of himself at times, and who is often prevented from doing so by a timely hint from the doctor. No doubt this was the spirit which imbued the elderly practitioner who brought me a straightforward case of hemiplegia. The patient walked into my room with characteristic gait, the affected arm hanging in front of him, the face drooping on one side. He took the patient's chair and I sat on his sound side and proceeded to feel the pulse at the wrist. Where-

upon the doctor drew near to me and whispered, "The other is the paralysed side." Then, lest this may have been noticed by the patient's wife, who was seated in the background, he walked up to her and engaged her in conversation so as to distract her attention in the event of my committing some further blunder. The motive was so generous and the action so fine that I never told him he had not done what he thought he had—saved me from an exhibition of crass immaturity.

Of other consultants I could say a good deal that might be appropriate under the title of my present article, and of course they could say a little about myself. Exactly why one consultant is chosen and another left would in itself provide a goodly number of stories not lacking in humour. I have occasionally earned an easy reputation by the accident of saying very little during a consultation: one is sometimes tired and sometimes one has a headache. I believe there are consultants who make a practice of judicious silence. A friend of mine tells the story of an eminent consultant whose forbearance in speech led to a curious misunderstanding on the part of one of the patient's friends. When the relatives were ushered into the room where the doctor and the consultant had conferred after the examination of the patient, they found the eminent "specialist" standing with his back to the fire looking very wise. They waited for him to begin his summing-up, but the great man said nothing. The sick man's son—Semitic—mistaking the nature of the oracle's slowness in committing itself, whispered to the practitioner, "Won't he talk until he has had his fee?"

On the other hand the consultant may be too voluble, too mentally alert, and bursting with unnecessary, not to say undesirable, details. I was once chosen to represent a senior colleague at a consultation because the latter was away for a short holiday. The patient was old and was slowly dying of "a complication of disorders." Consultations were held weekly, and for the convenience of the numerous relatives who gathered at the house on these occasions to hear of the old man's steady progress towards another sphere, the time selected was 10 o'clock in the evening. I was informed of the patient's condition and of the details in the euthanasia, which seemed to me to be entirely according to our art. I was also enjoined to be very brief in my comments downstairs—an injunction which appealed to me as quite appropriate. To the large array of sons, daughters and "in-laws" collected in the library I said very little, confining myself to the fact that some strength had been lost during the week (as was inevitable), but stressing the point that the patient was not suffering, either physically or mentally. I noticed that the dying man's wife, a little old lady using an ear-trumpet, was

sitting with her eldest son in the front row. (A distinguished surgeon who, I was informed, attended the consultations regularly because there was a small ascites present which, all were agreed, did not indicate paracentesis, wisely forebore making any comments at all.) Altogether my conduct appeared exemplary, for satisfaction was expressed by the son of the house and by the doctor; I was handed a large cigar whilst the friends drove off to their respective homes.

A fortnight later I was surprised to receive an invitation to join in the consultation again, and still more surprised to find my senior colleague, who was, I knew, back at work, was not present. Somewhat puzzled, I went through much the same process. The patient was nigh to death (a fact which led my surgical friend to add his view that there was still no need to evacuate the small collection of peritoneal fluid). The talk downstairs was even shorter, if possible, than before. I accepted the doctor's invitation to drive home with him so that he might tell me what had happened during the intermediate consultation. It appeared that my senior had caused grave displeasure, hence my being sent for in lieu of him. Whether it was that his holiday had stimulated him to renewed interest in the case, or whether for the moment he thought himself giving a clinical lecture, I cannot say. He held forth at some length in talking to the family conclave, drew graphic pictures of the state of the heart, blood-vessels, kidneys and liver, and explained exactly why the functions of these organs were failing. He was suddenly interrupted by a cry of distress from the old lady in the front row; several juniors ran to rescue her and to comfort her, and the meeting "broke up in disorder." In the hall, on saying good-bye, the eldest son remarked to the doctor, "Will you bring Dr. X next week, instead of Dr. Y? You see, we know that our father is dying but we didn't want to know how rotten he is." X.

DIET FROM THE PHYSICIAN'S STAND- POINT.

By W. LANGDON-BROWN, M.D., F.R.C.P.

HE story is told of Sir William Gull that at a medical dinner-party he was discoursing on a favourite theme of his. "It is the old story," he maintained, "*Plebs vult decipi.*" "Which being translated," said Dr. Martin, then one of our physicians, "means, the public likes to be gulled."

Whether or no the public likes to be gulled, it certainly likes, and indeed demands, to be dieted, and it is often gulled in the process. It may seem curious to start an article on the influence of diet in disease by declaring that its importance has been much exaggerated. It would perhaps be fairer to say that it has been much misunderstood. It does not need much knowledge of chemistry to recognize that red wine cannot make red blood, nor chalky water produce gouty chalkstones. Yet both beliefs are wide-spread.

The instinctive craving for a mixed diet is the unconscious expression of a physiological need, for no one foodstuff contains all the elements required in the appropriate proportions. Yet many "crank" diets are grossly disproportionate to the needs of the body, both in quantity and quality. And even in more orthodox practice, our dietary restrictions and prescriptions are too much dictated by fashion. Except in cases where we must forbid something for a perfectly definite reason, our patient's likes and dislikes should be carefully considered, whereas it is our own likes and dislikes which tend to recur in our dietary schemes. Given a certain knowledge of the physician, one can predict fairly accurately what he will recommend to any patient, whether a purin-free diet, lactic acid oats or uncooked vegetables. The dyspeptic is often a diligent seeker after advice, and when he tries to harmonize the various dietary gospels he has received, his opinion of our profession is not enhanced.

"There is to be observed a sort of fashion running through these restrictions," said Sir William Roberts, "yet I know not on whose authority they repose. . . . They are for the most part quite unmeaning; they stand on no ground of science or experience, and are gratuitously punitive to our patients."

Yet it is extraordinary how quite opposite methods of restriction do good. The explanation is that such a patient ordinarily eats and drinks too much. Variety of diet stimulates his appetite, while the monotony entailed by abstention from so many pleasant things results in his eating less altogether, with benefit to himself.

Indeed we have learned of late years that a fast may be one of the most useful dietetic measures. Its value in diabetes is beyond question, but it may also be very helpful in asthma, while in various alimentary disturbances nature enforces this therapeutic measure on the patient. I have even heard it suggested that Moses enjoined occasional fasting on the Jews because, without knowing why, he found it suited, as it naturally would, a race so prone to glycosuria. And so a hygienic measure was translated into a divine command.

Two other things we have learned of late; the first

is the enormous value of those accessory articles of diet known as vitamins. This was a death-blow to the diligent search for synthetic foods, and proved another call for a return "to nature." The interaction of light and vitamin A is one of the most fascinating chapters in recent medicine, affording a scientific basis for treatment by light. But apart from deficiency diseases due to gross vitamin defect, like rickets, beriberi, scurvy and pellagra, we are beginning to realize how many vague conditions of ill-health are due to minor degrees of the same defects. In this connection McCarrison's observation of the influence of vitamins on the nutrition of the colon deserves mention.

The second is the scientific interpretation of the old adage that one man's meat is another man's poison, as illustrated by the toxic idiopathies. Morley Roberts has made the profound remark that "Immunity is assimilation." There is one flesh of birds and another of beasts. From the welter of amino-acids which result from the disintegration of food proteins each animal has to build up its own characteristic and specific tissues. Specificity is chemical as well as morphological. To some foreign proteins we are naturally immune, *i.e.* we can assimilate them automatically; to others we acquire immunity, *i.e.* we learn to assimilate them. But to some foreign proteins immunity is not congenital nor can it be acquired. The tissues continue to resent the introduction of such. They will not assimilate them. Richet has defined anaphylaxis (and the same would apply still more to this phenomenon known as allergy) as the last stand of the race against adulteration of its protoplasm. In extreme degrees they are fatal because assimilation would mean too profound an alteration of bodily structures. In lesser degrees allergy declares itself in violent attempts to get rid of the foreign invader. Yet for others such substances are not toxic at all.

Coming to more ordinary topics, it is clear that the chef has often anticipated the physiologist. Desiring to encourage appetite he begins the meal with *hors d'aevres* and soups—and then the physiologists discovered that condiments and meat extracts increased the acidity of the gastric juice. The physician followed by forbidding these delicacies to the hyperchlorhydric. Applying the same principles, he divided the proteins into those which contained substances likely to cause such secretion and those which did not. He built up a diet for peptic ulcers which was rich in the latter group while avoiding the former, discovering that a diet of proteins which did not stimulate the production of acid helped to fix such acid as was present in harmless combination, while flatulent distension was avoided by cutting down the starch, digestion of which soon comes

to an end in the hyperchlorhydric stomach. He was driven to seek such methods, moreover, when he became convinced of the very small amount of protein that could be absorbed from rectal feeding. The case against giving fat in this way is even stronger. "A little food in the stomach is worth a great deal in the rectum." Few attempt to give more than water, salt and dextrose by this channel now.

When he learned how complete is the disintegration of food proteins he became sceptical of the possibility of their running through a damaged kidney. He ceased to regard eggs as anathema in nephritis. Indeed, Epstein has shown that in chronic nephritis of the hydræmic type, with dropsy but no nitrogen retention, an abundant diet of proteins without much extractives may be positively beneficial, and that fat may increase oedema. But in acute nephritis, in which nitrogen retention is marked, he is learning that even his favourite milk diet may be injurious, because of both its protein and fat content. And so he has recourse to fruit-juice and sugar to tide the patient over this phase. He knows now that the colour of a meat is no guide to its purin content; to tell a gouty patient to take sweetbread and avoid mutton is to achieve the opposite to his real aim. But faith in the digestibility of starch, however administered, dies harder. Said Sir Clifford Allbutt, "There is no superstition more tenacious of life than what which prescribes carbohydrates to all dyspeptics as 'so digestible,' and into weak stomachs, ready to dilate, is thrown a mass of such a dish as rice-pudding—a bulky food, imperfectly salivated, and peculiarly apt to decompose with the disengagement of volumes of carbonic acid gas." A dyspeptic, whether of the hyper- or hypochlorhydric type, should have his starch in a crisp, dry form, such as toast, biscuit or rusk, so that it may be thoroughly insalivated. "Digestion starts in the mouth, and indigestion often starts there too." If for any reason starch cannot be managed in this form it should be malted first. We should also remember that when carbohydrates are given with protein they are retained longer in the stomach than if given by themselves. In the latter case they pass quickly into the sphere of influence of the pancreatic juice. For some dyspeptics, therefore, it is good to give chiefly protein at one meal and chiefly carbohydrate at another, as in the continental breakfast.

It is hardly necessary, and certainly impossible in this article, to describe the revolution in the dietary treatment of diabetes. Suffice to say that the old attempts to find a diet free from carbohydrate are recognized as fallacious. The abundant diet of protein throws fuel into the flames of an already exaggerated katabolism, while excess of fat produces the smoky flame of a toxic

ketosis. Neither in diabetes nor in nephritis do we look upon fat as the harmless food it was formerly considered. In diabetes it is no advantage to replace hyperglycaemia by ketosis. A balanced diet, at a lower level, is now our aim in diabetes; fortunately the discovery of insulin enables that level to be higher than was formerly possible. Fat cannot be completely oxidized in the absence of carbohydrates, and we are learning the advantage of glucose and the disadvantage of fat when the oxidases are at a low ebb, as in hepatic toxæmia. But the very readiness with which carbohydrates, once digested, are assimilated tells us that in the production of obesity they may be more potent than fat itself. Bearing in mind how frequently pathological obesity is a latent glycosuria, there is another reason for their limitation.

The mechanical aspect of diet has also received more attention. No longer is it considered desirable that food should be completely absorbed, for it is recognized that a certain amount of residue is necessary for due intestinal peristalsis. Cellulose is useful for this purpose, but as it may undergo fermentative changes in the cæcum, it may be unsuitable in some cases of intestinal stasis. If foods containing cellulose have to be removed from the diet, paraffin and agar have to be resorted to in order to increase the bulk of intestinal contents. In typhoid fever too much attention was paid formerly to the state of the food as it enters the mouth, and not enough to its condition when it passed over the ulcers. Yet it is clear that milk can form irritating curds in the bowel, while jelly becomes liquid there. Oxaluria is a condition which may mechanically irritate the kidney, and call for abstention from strawberries, rhubarb and spinach, and their replacement by foods rich in magnesia, such as peas and beans.

But I finish as I began—if the patient insists on being knocked off something, have a definite reason for doing so. Discourage crank diets; I recently saw a woman slowly kill herself by a devotion, amounting to an obsession, for the Salsbury treatment. It was quite another Salsbury who said that “for the soldier, nothing is safe; for the priest, nothing is innocent; for the doctor, nothing is healthy.” It may seem heretical, therefore, to declare that for the great mass of mankind and for the majority of patients a mixed diet of plain fresh food is eminently healthy. But that is my belief.

A lost-looking lady was encountered by a nurse in the waiting-room and asked what she wanted. The lady replied: “I've come from Harley Street Ward and I've been told to look for a green fern.”

“HOW NOT TO PRACTISE MEDICINE.”

By AN AUTHORITY.

FHE path of the physician is thornier than is that of the surgeon. This is true not only in the practice of the therapeutic art—if indeed such a compliment can be paid to the more assertive branch of the profession—but also in the compilation of an article headed as is this. The surgeon, if he be wise, will never undertake the management of a case whose treatment he knows to be beyond his powers; instead, he hands it with a superficial air of generosity to the physician, whose congenital benevolence blinds him to the guile that underlies the gift. Thus the heading of an article “How not to be a surgeon” could fairly precede a detailed and carefully polished compendium entitled, “Let all but the easy cases well alone,” or “How to gull the physicians.”

The physician, being of an ampler, more generous spirit, instead of following this line, as well he logically might, is content to remain the butt, and is willing to assume the care of many cases whose treatment is futile, merely to admit to some degree of shelter the poor helpless vagabonds whom his younger brother of the scalpel has so heartlessly cast out. The mistakes of the surgeon shout to heaven; all are there to see—the anæsthetist, the nursing staff, the assistant, the dressers. The physician is as often blamed for his success as he is praised for his failures. Who, then, shall criticize the former for following the easy path, or the latter for an occasional stumble?

It is thus clear that an editorial request to write on the subject “How not to be a surgeon” can be turned aside with some facile gesture such as has been indicated above. Far otherwise will be the task imposed by the complementary question. Compliments here will rather embarrass by their spurious pertinence: “Who so qualified as you to write on such a subject?” or “How well you have accomplished your task”; “The hand of a man who knows his subject”—these and like shafts are destined to probe the quivering flanks.

Nevertheless the physician may avoid many wounds at the hands of Fate if he will guard himself with the greaves of logic and will put on the breastplate of mental honesty.

The qualities necessary to the exercise of his art can be grouped under two heads—those of the heart and those of the brain.

Kindliness must never desert him. The most verbally incontinent gossip must be dealt with gently; even if the mailed fist become necessary the velvet glove must always conceal it. It ought never to be forgotten

that the doctor is a species of "loud speaker," that every word of his to a patient is many times amplified in importance and that all patients have at the moment a more delicate receptivity. The faintest shade of impatience becomes a sharp gust of anger, the slightest hint a dictum. Thus kindness must ever be tempered with equanimity. The facts of the situation must be levelled out into a rather flat landscape, whose tones are not high enough to be exaggerated by imagination.

A sense of humour is even more necessary for the good of the practitioner's own soul than for that of his patient.

The question of absolute openness is one requiring more consideration. Though self-deception is unfor-giveable, deception of the patient may occasionally be necessary. The hackneyed theme "Should a doctor tell?" can be applied to many cases, and the answer will always be varied by the facts of each individual situation.

The essential qualities of the brain are easier to discuss. By them is measured a man's ability, but to them alone can never be attributed his success. Personality, and indeed that side of therapeutics that is dependent upon suggestion—a matter of no little importance—are compounded of a mixture of qualities of the heart and of the head. The former is often in the greater proportion. The best examinee is frequently a minor success—in the best sense of the word—in practice. It does not do to regard human beings as test-tubes—the thought dwelling in the eyes is so easily read by the patient.

Again, lack of academic knowledge is not necessarily a matter for grief; it can never be expected of a man by his fellows individually, or by his country legally, that his performance should rise above his capabilities. These must only be of reasonably average merit. But however sparsely equipped be his armoury—and most are better stocked than the owner is aware of—the weapons must be kept polished and used logically and truly.

Accurate observation, logical deduction, a reasonably good memory—these are the essentials, and of the three the first is the greatest.

The statement, if it be true and accurate, "I have seen," is above cavil, and any observer of a sufficient number of cases will have always with him a mental text-book superior to any made with hands, provided always that he be served well by his two compilers—Memory and Observation. If, in addition, he have Logic as an assistant editor he need fear no reviewers. But reliance upon personal observations and experience, though it must take the precedence of living over dead facts, is not enough. No one can afford to remain

ignorant of the experience of others: the recluse is self-limited; self-limitation is stagnation. Reference to the work of others will stimulate, and will serve as the means by which a greater mass of knowledge can be accurately wielded than would ever be in the capacity of a single mind to carry. Facts that are unknown must be readily traceable through books of reference.

Finally comes absolute honesty to self and to others in the face of difficulty. The man who never says "I don't know" to others cannot be comprehensively honest. He who never says it to himself is merely a fool. The refusal to admit this, or rather the reaction against this, constitutes one of the greatest and most ridiculous attitudes of the medical mind. It is probably a relic of the witch-doctor days, when to be wrong spelt ruin. The survival is to be seen in several forms, but its central idea is that of impressing.

The least harmful type of the disorder, and to on-lookers perhaps the most amusing, is that of impressing oneself. The victim will mouth great syllables, he calls phlegm effluvia, worms vermiform parasites, dropsy anasarca, and so on and so forth, his eyes the while swelling with self-admiration. This is an innocent type of the malady. It is when his impressiveness is transferred to the patient that the malignant form become apparent. The former is mere pneumocephaly; the latter is a malignant pneumoma. The victim of the disorder will try to impress in many ways. He will assume a manner of gruffness or a weightiness of speech that he has thought effective in someone else, to whom, indeed, it was natural, and in whom therefore it probably was effective. He will array himself in spats, tarsal or cervical, or both, will assume a white waistcoat and a coloured tie, will wear a top-hat on the back of his head, as though to say to all the world, "Earls are my washpots; upon Duchesses do I triumph." Other minor manifestations are an air of great business, the appearance of not having time to stop, the flaunting of loudly-painted motor-cars, the worship and futile brandishing of intricate apparatus; again, the habit of keeping patients needlessly waiting, with the implied hint of being greatly sought after. These may all and each be diagnostic.

It must, however, always be borne in mind that only in the artificiality of the attitude does harm lodge. There are many men of great personality to whom certain habits of mind, speech and manner are natural, but by their personalities do they stand out and by no trick of the tongue. There are men who naturally dress in ways different from those of their companions; it is to their honour that they maintain their individuality. There are even men who can afford expensive cars, and whose whim it may be that these be plum-coloured,

maroon or beige. There are finally radiologists, the mysteries of whose temples are necessary to their livelihood. These are following their natural impulses or necessities. It is the fool who swells himself up with wind like the frog in the fable and who makes himself and his profession ridiculous. His folly, moreover, is dishonest.

THE ANATOMY OF THE PROSTATE IN RELATION TO SURGERY.

IT is well that those who make mistakes should sometimes have the opportunity of correcting them. My conscience in this matter is far from clear, and when certain facts taught by me in the Department of Anatomy are recalled, I see how many of the misconceptions surrounding this difficult subject have arisen. The sole consolation is that I am in distinguished company. This article is, then, an expression of repentance for past mistakes, and an attempt to clear away some of the difficulties which the student meets in understanding how the prostate gland can possibly be removed.

It will be remembered that the prostate is a gland furnishing both an internal and an external secretion, the exact nature of the former being still a matter of dispute. Normally it is roughly the size and shape of a horse chestnut—a time-honoured description—and is situated at the neck of the bladder, to which it is connected by its base, while its apex rests on the triangular ligament. In addition to this it presents a posterior surface, with a vertical median groove, in relation to the anterior surface of the lowest part of the rectum, and two antero-lateral surfaces in relation to the back of the pubes. Traversing the gland is the prostatic urethra, running a curved course with a forward concavity. It is crescentic in section, due to the projection of a vertical elevation on its posterior wall—the verumontanum. This forms the widest portion of the urethra. Opening into it on the verumontanum are the two common ejaculatory ducts, which run an oblique course through the gland, entering it immediately posterior to the attachment of the bladder. Between and below these is the homologue of the uterus—the sinus pocularis—while in a deep groove on either side of the verumontanum are the openings of the numerous prostatic ducts.

To consider more carefully the connections of the gland: like other glands it has a covering or capsule of fibrous tissue, which is intimately adherent to its glandular substance. Superiorly it blends with the

muscle and fibrous tissue of the base of the bladder and with the sphincter vesicæ muscle which surrounds the termination of the urethra. The superior relations are shown in Fig. 1.

The infero-lateral portion of the prostate comes into relation with the upper surface of that portion of the levator ani which arises from the back of the pubes. From this it is supposed to derive a mysterious sheet of fascia, variously known as the pubo-prostatic fascia or anterior true ligaments of the bladder, which are part of the visceral or recto-vesical portion of the pelvis fascia. It is also supposed that this pubo-prostatic fascia covers the prostate in such a way that it provides

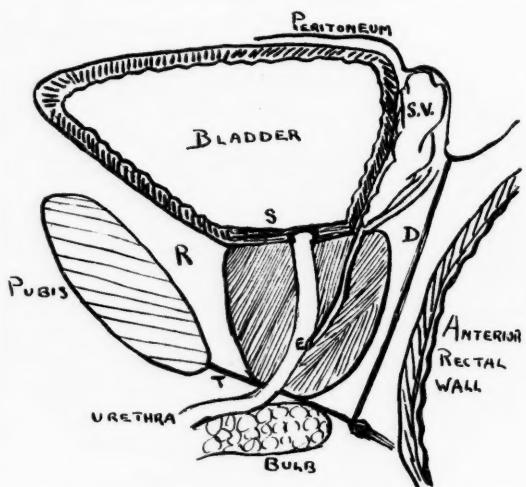


FIG. 1.—SAGITTAL SECTION THROUGH THE PROSTATE (DIAGRAMMATIC). R. SPACE OF RETZIUS. S.V. SEMINAL VESICLE. D. FASCIA OF DENONVILLIERS. E. OPENING OF COMMON EJACULATORY DUCT. S. INTERNAL SPHINCTER. T. TRIANGULAR LIGAMENT.

a sheath, which posteriorly is prolonged downwards and upwards, separating the prostate, bladder and vesicles from the rectum. I say "supposed" because, though the prostate in common with other pelvic viscera is covered with connective tissue, filling up the "dead spaces," anchoring the viscera, and providing a supporting tissue for the vessels and nerves, yet it is impossible to demonstrate any sheath or envelope by injection or other methods. Certainly there is nothing comparable to the synovial sheaths of the tendons of the hand. The most careful dissector will fail to demonstrate anything more than two denser portions running to the pubes, which may be dissected into bands, and a well-defined sheet (if the specimen is fresh) in front of the rectum—the "fascia of Denonvilliers." In the words of Elliot Smith, "the pelvic fascia, as ordinarily described, is a myth."

In this connective tissue, best described as the pelvic cellular tissue, are the vessels and nerves of the organs. The prostate is surrounded by a very well-marked plexus of veins, which drain into the internal iliac vein by way of the inferior vesical veins. Its arterial supply comes from the inferior vesical and middle haemorrhoidal vessels, and sometimes also from the internal pubic artery.

It is from this highly vascular cellular tissue, open to the ready spread of infection, that, according to one of our most distinguished urologists, the prostate is enucleated in the operation of suprapubic prostatectomy. If this was actually done, the inevitable result would be pelvic cellulitis, as neither pelvic cellular tissue nor pelvic fascia presents any barrier to the spread of infection. But fortunately the term "prostatectomy" is a misnomer. The hypertrophic nodules of gland-tissue, whether they are believed to be derived from lobules of gland-tissue or from embryonic rests, do not involve the whole gland, the remnants of which are compressed and form with the fibrous capsule the "surgical" or practical capsule from within which the adenomata are enucleated.

There are two routes of surgical approach to the prostate : (1) The suprapubic route, which is the one commonly employed in this country; and (2) the perineal route, which, though of general application for the drainage of an abscess in the gland, does not give good results in the removal of adenomata, except in the hands of Hugh Young and his associates.

Use of the former route depends on the fact that when the bladder is distended, the peritoneum is raised up and separated from the anterior abdominal wall. The bladder is distended with 8 oz. of lotion, and a mid-line incision made, commencing one finger-breadth above the upper border of the symphysis pubis. The incision is carried down between the recti muscles, the fascia transversalis incised, and the extra-peritoneal fat reached. It is important that the fatty tissue should not be separated from the posterior surface of the symphysis pubis, or any downward extension made, in order not to open up the loose cellular tissue of the space of Retzius. This space is situated above the prostate and between the pelvic surface of the symphysis and the bladder. The fat is very loose, and a considerable potential space is present into which fluid or infected material might gravitate. If the space is accidentally opened, a drain should be inserted.

The extra-peritoneal fat is incised transversely and the anterior surface of the bladder brought into view. This may be recognized by the presence of large tortuous veins on its surface, by obvious muscle-strands, and by its pink colour. At this stage of the operation the lower

limit of the parietal peritoneum will be seen as a fold on the surface of the bladder. It should be pushed upwards and gently stripped from the bladder with the finger. The bladder is then secured with tenaculum forceps or retaining sutures, and incised in a vertical direction as high up as possible. A lower incision will tend to sink down behind the symphysis when the bladder contracts. The next step is the removal of the adenomata, and the surgeon has to find some line of separation or cleavage between them and the surgical or practical capsule already mentioned. To do this the right forefinger is introduced through the internal sphincter to dilate it, and the mucosa of the prostatic urethra "cracked" immediately below. This is done along the line of least resistance, usually on the anterior or lateral wall, and the line of cleavage is found. The finger is swept round from side to side, separating the adenomata from the prostatic tissue outside them. Assistance is obtained by inserting the index finger of the other hand into the rectum and pressing the prostate upwards so that it moves about as little as possible. The ejaculatory ducts usually escape injury as they are displaced downwards by the adenomata. Some surgeons find it more convenient to reach the line of cleavage by tearing through or incising the mucous membrane of the base of the bladder, the "trigone," over a projecting portion of prostate.

In the perineal route an incision like an inverted "U" is made in the perineum, the apex being $1\frac{1}{2}$ in. in front of the anus, and the lateral portions running back towards the tuberosities of the ischium for about 2 in. This incision is carried through skin and superficial fascia, exposing but not opening the posterior part of the bulb of the urethra. The space between the transverse perinei muscles and the levator ani is opened by blunt dissection, keeping in front of the rectum and behind the triangular ligament. At this stage the central tendon of the perineum is cut across close to its attachments to the bulb. The surgeon is now separated from the prostate by the fascia of Denonvilliers, which can be seen as a pearly-white sheet. It stretches from the triangular ligament below to the pocket of peritoneum which separates the posterior surface of the bladder from the rectum. This pocket must be avoided, especially in operations on the seminal vesicles, and may even be injured in an operation on the prostate. It should therefore be pushed up out of the way. Adenomata are removed by incising the practical capsule of the prostate, rather less than $\frac{1}{2}$ in. to either side of the vertical median groove, in order to avoid injury to the ejaculatory ducts.

In conclusion, brief reference should be made to the rectal examination of the prostate. As already seen,

the gland is in relation to the anterior wall of the lower part of the rectum, and a finger inserted in the rectum may palpate its posterior surface and recognize the faint median groove. It is difficult for the tyro to determine how large a prostate is. Normally the surface feels flat, and an enlargement may be detected by feeling a convex projection on either side of a more marked median groove. A deep lateral sulcus will be found in the rectum when the projection is at all marked (see Fig. 2). The size may be estimated in finger-breadths by moving the finger across the gland, anything above three being abnormal. This is a very rough

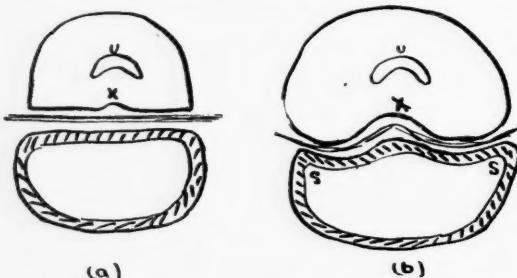


FIG. 2.—DIAGRAMMATIC SECTION THROUGH PROSTATE AND RECTUM. (a) NORMAL. (b) ENLARGED. X. MEDIAN VERTICAL GROOVE. U. URETHRA. S. LATERAL SULCI IN RECTUM.

guide, but may be of some use. A more accurate estimate can be made by the use of the cystoscope, when the extent of the upward enlargement of the prostate into the bladder may be seen, and also the degree of obstruction to the prostatic urethra which it has produced.

J. B. HUME.

THREE CASES OF IMPACTED GALL-STONES CAUSING ACUTE INTESTINAL OBSTRUCTION.

By E. W. G. MASTERMAN, F.R.C.S.

GALL-STONE obstruction is an uncommon condition, and the three cases given below are good samples of these kind of cases.

They are all in women in late middle or old age (58 to 72). In all the history gave no certain indication before operation as to the nature of the obstruction—there was no history of jaundice, biliary vomiting or gall-stone colic. In the first case we had, regrettably, the opportunity for a post-mortem, and found, as is usual, a wide fistula formed between the gall-bladder and the adherent duodenum, through which the gall-stone had passed into the bowel. In all three cases the stone was caught in the ileum, and in two the stone had stuck in a loop of the ileum which had prolapsed deeply into

the pelvis. The two cases which recovered both had a discharge from the closed incision some days later due apparently to some slight leakage, and I should, in a subsequent case, certainly put in a tube rather than sew up as I did. Another lesson which these cases teach is that a case of intestinal obstruction coming in old age with no local signs, which is ordinarily due to a malignant growth, *may* be of this nature and therefore is urgent. In all these cases the incision on the left side, as if for a colostomy, proved the best.

By a curious coincidence the first two cases were operated upon on successive days, although the three cases are the only ones of their kind occurring among many hundreds of cases of abdominal operations done here during the last ten years. And by another coincidence the sister of the second case was operated upon for cholelithiasis here while Case 2 was in the Hospital.

CASE 1.—S. B., at. 72.

Admitted March 30th, 1921, with intestinal obstruction. Gave a history of "dyspepsia" for eight years. She stated that she had had complete constipation for three days and had been retching for four days, and once vomited; she had passed flatus and had had considerable abdominal pain at first, but none the last two days. She was rather emaciated. The tongue was dry and brown, and the abdomen distended, tympanic and very tender. The rectum was full of faeces, after the removal of which the patient was relieved. The case was thought to be one of obstruction due to a growth, and was brought to the Theatre on April 1st, 1921, for the operation of colostomy. The condition of the patient was such that I was most unwilling to operate, but thought that she might stand a quick colostomy, which would probably give her relief.

On making the usual incision, instead of the obstruction being found in the colon, the small intestines were found distended and a coil of ileum was found lying in the pelvis, containing a large calculus. In removing the coil of intestine it gave way at the site of the stone. The rupture was enlarged longitudinally and a large gall-stone was removed. The rupture was closed with three superimposed tiers of sutures, the bowel was cleansed and a drainage-tube inserted. The condition of the intestine was so doubtful that, had the patient's condition permitted it, a resection would have been made, but it was obvious that the patient could not stand a longer operation. The patient unfortunately did not rally, and died at 11:25 a.m. the next morning.

At the post-mortem the fistulous opening in the gall-bladder by which this large gall-stone had passed into the duodenum was clearly demonstrated.

CASE 2.—S. F., at. 58.

Admitted April 2nd, 1921. Gave a history that she had had a similar attack five years previously, but that she had passed "something hard" one day by the bowel and was relieved.

This present attack began one week previous to admission with diarrhoea and vomiting, followed by constipation. The last two days before admission the vomiting was very frequent; there was also some pain in the left iliac region. Examination of the abdomen and rectum gave no indication as to the source of the obstruction; there was no distension, rigidity or tenderness. The condition was thought, as in the previous case, to be due to a malignant growth.

An incision as for colostomy was done on the day of admission, and on inserting a finger a large gall-stone was found in the lower end of the ileum and the loop of bowel lying, as in the last case, in the pelvis. The loop of bowel was carefully brought out of the abdomen, and after being packed off, the gall-stone, which was larger than the last one and was tightly impacted in the bowel, was removed by a longitudinal incision, which was closed in two layers with no drainage. The stomach was thoroughly washed out on the operating table. She did very well for nine days, with a temperature only on one occasion above 100°, but on the eleventh some foul-smelling pus appeared, and, on removal of the stitches, welled out of the wound. Considerable sloughing of the subcutaneous tissue followed for a time, but in another ten days the wound had become

clean, and was firmly healed when she was discharged quite well on June 17th, 1921.

She has been in good health since, except for an incisional hernia, which is satisfactorily controlled by an abdominal belt.

CASE 3.—M. H.—, at. 70.

Admitted July 12th, 1925, with a statement that she had been troubled with constipation for the last three months, and had acute abdominal pain since the 10th, the vomiting gradually getting more frequent and profuse, and on admission was apparently sterco-raceous. The abdomen was distended, tympanic and tender, but no mass was felt. She was operated upon at once, the incision being made as for colostomy, through the left rectus. On inserting finger, a loop of inflamed, but only moderately distended, ileum was felt, containing a large gall-stone, which was immovable in the bowel. The loop was drawn out, packed round, and the stone extracted. The wound was closed in two layers. On the 20th some fecal discharge occurred through part of the wound, and a small tube was inserted. The discharge, which was at first fecal, became purulent. By July 19th, 1925, however, the wound was almost healed, and she was discharged fit on August 18th, 1925. Like Case 1, the patient was a very fragile old lady, and her urine contained a heavy cloud of albumen, and, considering her apparently desperate condition on admission, she did very well.

Dimensions of the Calculi.

Case 1 : Length 2 in., breadth 1 $\frac{1}{8}$ in., weight 323 gr.
Case 2 : " " 1 $\frac{1}{4}$ " " 354 "
Case 3 : " 2 $\frac{1}{8}$ " " 1 $\frac{1}{4}$ " " 388 "

The first two calculi had probably become somewhat lighter through desiccation since removal in 1921.

Each stone has a more lightly-coloured upper end, where, in the case of the largest stone, this is a distinct facet. The lower end is more definitely rounded off. In all the surface is "greasy" to the feel. The colour of the older stones is a greenish-brown; that of Case 3 is a light yellow-brown, darker in patches, and the lower end a creamy white.

DIET AND DIETING.

The Impressions of a Lay Observer.

WITH much reluctance I have consented to offer some humble observations from the lay standpoint on diet and dieting. Few subjects cover a wider ground or offer more ample material for discussion. And that is because, speaking of dietetics merely as applied to normally healthy persons living under normal conditions, it is impossible to lay down any hard and fast rules. As to the influence of diet upon health, we are all agreed. But individuals vary in their food requirements just as they vary in the capacity for food and in their power of assimilation.

Some will thrive on a diet which in others would be attended with disagreeable consequences. Many, again, can preserve a condition of good health on a food allowance which, measured by accepted principles, would appear to be wholly inadequate. That is to say, there is no ideal formula for a perfect regimen. To

seek such a formula is to pursue a will-o'-the-wisp, since the character and quantity of food adapted with success in a given instance might be entirely unsuited in another. Shakespeare probably had this in mind when he said: "They are as sick, that surfeit with too much, as they that starve with nothing." Medical science in relation to food values has, of course, greatly advanced since those words were written, and when the sole aim was to furnish the greatest quantity of nutriment without overloading the stomach. But with the lapse of years has come economic transformation, tending more and more to food adulteration, to the use of food preservatives, to cold storage, to canned goods, and generally to conditions that rob raw food substances of much of their natural virtues.

These penalties of a progressive civilization have, of course, added to the difficulties and complexities of the diet question, which, like the poor, will always be with us. In most discussions on the subject the tendency is to ignore the really important fact that circumstances alter cases. The diet suitable for adults can only be determined by considerations personal to each adult. It cannot be prescribed indiscriminately for all and sundry. What would be said, for example, if the same fare should be ordered for a person of sedentary occupation and habits as for the open-air labourer? But the trouble is not merely in disparity of vocation and environment. It is no less to be found in the different food requirements of different persons living under conditions common to them all.

Having demonstrated that diet is not and cannot be made an exact science, I pass on to some humble conclusions at which I have arrived from observation. In the first place I would lay down as a general axiom that a natural diet must be composed entirely of wholesome food. The argument may be opposed that "wholesome food" is an elastic phrase. It may be. But it conveys to my mind fresh meat, fish, vegetables, fruit, etc., prepared hygienically, and in such a manner as to preserve, as far as possible, their nutritive and health-giving qualities.

I would resolutely bar the *table d'hôte* dinner, although frankly confessing to a partiality for it. I would veto without hesitation the consumption of high game, or of any foodstuff that had reached the stage of decomposition. In principle, also, I am opposed to meat as an article of diet more than twice a day, and would suggest as an aid to comfortable condition of body and mind a discreet abstinence from rich sweetmeats. The habit of eating between meals is no less to be proscribed, since it imposes a quite unnecessary strain upon the digestive organs.

And now emerges the knottiest problem of all—to fix

the daily quantum of animal and vegetable foods for normal adults. Should we be rationed?—so much of this and so much of that, as is done in many public institutions, where great numbers are housed and fed. Science has certainly not succeeded in bringing these institutions into line as to a proper feeding allowance. Even the food expert, whose recommendations are with base ingratitude so generally ignored, finds it convenient to tread cautiously when dealing with this aspect of diet.

But when all is said and done, it is knowledge of oneself that is the best guide to a suitable diet. Too many are apt to regard the question of feeding as a matter of rule-of-thumb—as involving only the provision of any form of edibles with which to fill the vacuum so abhorred by Nature. And thus are digestive and other physical disorders engendered. Little more than a superficial acquaintance with the subject is needed to prove the wisdom of the trite aphorism, "One man's meat is another man's poison."

To sum up, therefore, I would urge, as a lay observer, with respectful deference to the medical profession, and to the food experts in particular, that the royal road to a beneficial diet is through the avenues of common sense and experience.

M. R. KING.

THE ABERNETHIAN SOCIETY.

HE following is an attempt to outline the history of the Abernethian Society with a view to interesting Freshmen and others in the purpose for which this, the oldest of our student societies, stands.

I have taken the liberty of making an abstract of the history of the Society from those excellent works, *The History of St. Bartholomew's Hospital*, by Sir Norman Moore, and *A Brief History of St. Bartholomew's Hospital*, by Sir D'Arcy Power.

I should like to take this opportunity of thanking Mr. A. W. L. Row for his kindness in presenting the Society with a photograph of the presidential chair, a print of which accompanies this article. The original is a most artistic piece of work in photographic light and shade.

The Abernethian Society is the third oldest Medical Society in Great Britain, the Edinburgh Royal Medical Society being the oldest, and Guy's Physical Society next.

Our Society was originally founded in 1795 as the "Medical and Philosophical Society of St. Bartholomew's Hospital," and in its youth John Abernethy and Dr. Richard Powell were its mainstays. Amongst other celebrities who played active parts in the earlier meetings of the Society were Sir William Lawrence, Surgeon to this Hospital, and James Macartney, who became Professor of Anatomy at Dublin.

John Abernethy was the first President, and was a most regular attendant at the meetings until his health began to give way. Simultaneously the Society became progressively less flourishing, and in 1832 the Library belonging to the Society was sold to the Medical School, and the meetings discontinued. In 1835 affairs began to look up again, and on February 6th of that year (Sir James) Paget, then a first-year student, read his celebrated paper on "Trichina spiralis"—an organism which he had discovered residing in the muscles of certain of the dissecting-room subjects.



THE PRESIDENTIAL CHAIR.

In the winter session of 1847–48 the Presidential Chair (see photograph) was purchased for the sum of £50, and it now stands in the Abernethian Room, and is used at all the meetings of the Society.

Previous to the purchase of this chair John Abernethy and his succeeding Presidents used to sit in "Sir Percival Pott's old chair." John Abernethy appears to have possessed a great admiration for Sir Percival Pott, for on several occasions he regaled the Society's meetings by relating incidents and stories concerning Sir Percival.

From 1850–1856 the Transactions of the Society were published and are now in the Library. They consist principally of papers read to the Society, and are of great interest.

Among the illustrious who used to take part in the discussions of the Society were Arthur Paget, Sir James Paget, Charles West, Luther Holden, Sir William Savory, and of more recent years those who now occupy exalted positions on the Visiting Staff.

The objects of the Society are to encourage accurate observation, the power of debate and *esprit de corps*. Students beginning or engaged in clinical work would be repaid a hundredfold by taking an active part in all the Society's meetings.

At the Clinical Evenings a member of the Junior House Staff presides, and those attending constitute a few recently qualified men, the remainder being students. These meetings afford an excellent opportunity to those of us who, through shyness, mental anxiety or what not are too timid to initiate a discussion on rounds, and who in a less awe-inspiring environment can give vent to our opinions by standing up and saying a few words.

H. B. S.

IDYLL.

FN trembling tones you told me of your dread,
Your abject fear.
It seemed to soothe your terrors when I said
That I was near.

And when at last with one unearthly cry
You, stupefied,
Lay silent there and senseless, it was I
Who watched beside.

I felt the flutter of your faltering heart,
And all the while
Your eyes were fearless, and your lips apart
In half a smile.

Lifeless you lay in everything but death,
Your form revealed;
And when I felt the fragrance of your breath
My senses reeled.

'Twas then I learned the object of your fear—
I stood dismayed
To see a masked and silent figure near
With naked blade.

Seizing you, he slowly raised his arm,
With steel ablaze;
But, fearless now, your eyes met his with calm,
Unflinching gaze.

* * *

That night, from Lethe's shadowed gloom you came,
Mute and pathetic.
For hours you vomited, but did not blame
The anaesthetic.

A. B.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

STARTING three weeks earlier this season than in former years we embark on a strenuous programme against almost all the first-class sides in the country. The team is, as yet, in the making, but promises to be as good as that which won the Cup two years ago. With Bettington as captain and H. McGregor and Butterly as vice-captain and secretary respectively we are in good hands, and the material is in the Hospital for an A XV. The final arrangement of the team must depend on the announcement of the new "House" in November, for four of the "regulars" will be departing unless they are appointed. "A," "Extra A," "B" and "C" XVs are being run regularly and start their fixtures early this month.

It is hoped that all non-playing members of the Hospital will support the teams—their presence and encouragement help materially. At Winchmore, where the stand has been re-painted and "done-up" generally, we are meeting such teams as Cambridge, Pontypool, Harlequins, Plymouth, Bristol, U.S. Portsmouth, etc., while in January Bradford pay us their first visit, and should be accorded a warm reception.

New recruits to the Club are very welcome, and we hope to receive strong support both on and off the field from men arriving this term. Names of new players should be given in to the Hon. Sec., from whom fixture cards are obtainable now.

W. F. G.

ASSOCIATION FOOTBALL CLUB.

THE Soccer Club opens this season with a match against the Old Citizens on October 17th, the earlier dates being devoted to trial games, in which it is hoped to find new talent.

Owing to the successes of last season, when we won the Senior Inter-Hospital Cup and reached the final round of the Junior Cup, stronger fixture lists have been arranged for the three teams.

Freshmen desiring to play are invited to add their names to the list of members posted in the Abernethian Room, or make themselves known to one of the players.

Officers for the season were elected as follows:

President: Sir CHARLES GORDON-WATSON.
Vice-Presidents: Mr. FOSTER MOORE, Dr. GOW, Dr. HURTLÉY.
Captain, 1st XI: L. B. WARD.
Vice-Captain, 1st XI: A. E. ROSS.
Hon. Sec., 1st XI: J. HUNTLEY.
Captain, 2nd XI: I. E. PHELPS.
Hon. Sec., 2nd XI: W. A. BELLAMY.
Captain and Hon. Sec., 3rd XI: T. F. TIERNEY.
Committee Men: W. A. MAILER, E. S. EVANS, A. CLARK.

UNITED HOSPITALS HARE AND HOUNDS.

THIS year the opening run of the season will take place on Wednesday, October 7th, from the Railway Hotel, West Wickham, at 3.30 p.m. Train leaves London Bridge station at 2.23 p.m.

The Annual General Meeting of the Club will not be held till Wednesday, October 14th, when it will take place at the Railway Hotel after the run.

On Wednesday, October 21st, a five-mile handicap race will be held at West Wickham, and all those wishing to enter should put their names down on the notice on the Athletic Club board in the Abernethian Room at once, as by so doing they will facilitate the handicapping.

Anyone who has ever attempted long-distance running, whether he has previously been successful or merely an "also ran," is urged to take up running this winter, as with a few keen supporters Bart.'s will have an excellent chance of winning the Inter-Hospital Cup in March. Anyone who has not attempted cross-country running before and who wishes to keep fit is also invited to join us.

Even if you feel you can shine at no form of sport, and therefore take part in none, give cross-country running a trial, for by so doing you may be able to help Bart.'s to recover a cup which has not been seen in the Library since 1906; in any case you will have had healthy exercise and spent a few hours in the country, both of which are good for the body and aid in refreshing the mind.

The United Hospitals Hare and Hounds Club was inaugurated in 1886, and in March, 1887, the first year in which the Inter-Hospitals cross-country race for the Kent-Hughes Cup was held, it was won

by Bart.'s. Other years in which Bart.'s have held this Cup are: 1902, 1904, 1905, 1906. Ever since the war it has been in the possession of Guy's, and it is quite time that Bart.'s put up a really hard fight to regain it.

Last season we lost the race by the bare margin of one point. It is the duty of all Bart.'s men, and especially "Freshmen," to see that this year the Kent-Hughes Cup is once more on view in the Library, and this cannot be done by merely looking on and criticizing while leaving all the work to those who have run previously.

Do not leave your efforts till the last minute. In the past few years we have been forced to persuade men to turn out even as late as the day of the cup race, whereas our opponents have trained their teams for several weeks. If a few members of the Hospital will show a little keenness and turn out regularly we have a very good chance of success in the Inter-Hospitals race; even if we do not regain the Cup we can at least feel that we have put up a sportsmanlike attempt for it provided we are backed by those who wish to do something for the Hospital with the true Bart.'s spirit.

Remember it is not easy to work hard unless you are fit, and no one can keep really fit unless he takes healthy exercise. Unfortunately exercise is not easily obtainable in London, therefore take the opportunities which are offered to you. H. N. W.

HOCKEY NOTES.

THE fixture list remains much the same as last year, with two additions, viz. Jesus College, Cambridge, and Haileybury College.

The drainage of the ground at Winchmore Hill has been improved, and it is hoped will now be able to cope with the severest downpours.

Last season, although marred by the abnormally wet state of the grounds, was very successful, especially for the second team. They won the 2nd division of the Inter-Hospital Competition, and lost only one match, whilst the first team reached the semi-final of the 1st division of the Inter-Hospital Competition.

This year ten of last year's first team are again available. J. H. Attwood has been elected captain and W. A. Briggs secretary.

Those wishing to play this season who did not play last should sign their names on the notice-board.

UNITED HOSPITALS' SAILING CLUB.

THE races for the Inter-Hospital Challenge Cup (presented by Mr. James Sherren, F.R.C.S.) were sailed on the Crouch at Farnbridge on August 29th and 30th, the 14-foot International dinghies belonging to the Club being used. St. Thomas's were the winners. The weather was fine on both days, but the lightness of the breeze on the second made the racing very fluky, and the times were poor. Dr. Herbert French, of Guy's, kindly acted as umpire.

In the first race, between Thomas's and London, the latter fouled a mark-buoy and were disqualified, but Thomas's failed to finish the course satisfactorily, and so the Committee decided that the race should be re-sailed.

Bart.'s crew were unlucky in their second heat, as, owing to the light wind, the tide caused them to foul a yacht anchored on the course at the end of the first round, and more distance was lost than could be completely recovered during the remainder of the race.

Details. Two rounds of a Z-shaped course (approx. 1½ miles long).

1st Round.—Thomas's (Chandler and Harvey) beat London (Lister and Milner) by 16 mins. Time 34 mins. 34 secs.

Bart.'s (Thrower and Watts) beat George's (Pye and Scott) by 2 mins. Time 36 mins. 19 secs.

Guy's, bye.

2nd Round.—Guy's (Roche and Tupling) beat Bart.'s (Gough and Watts) by 4 mins. 30 secs. Time 1 hour 23 mins. 34 secs.

Final.—Thomas's (Chandler and Harvey) beat Guy's (Roche and Tupling) by 10 mins. Time 1 hour 21 mins. 30 secs.

A second cup has been presented to the Club by a surgeon to this Hospital for single-handed sailing and a competition for it will be arranged next season. Notice of the Annual Dinner and winter meetings of the Club will be posted in due course.

CORRESPONDENCE.

"OLD TIMES."

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I thank you for your offer to send me the Hospital Reports, which I declined, not because the old Hospital has lost its interest for me, but because of my age. I think I must be one of the oldest Bartholomew's men living, as I celebrated my 90th birthday last month. My grandfather, "John Haines," was at Bart.'s, my father a pupil of Abernethy and a contemporary of "Stanley," whose house-surgeon I was. He retired during my year, and I became "Paget's" first house-surgeon. My grandfather gave evidence on smallpox in the House. My father made himself a Governor of the Hospital to vote for Paget, who was the first man who broke the rule of the assistant surgeon's being chosen from the articled pupils of the surgeons. Paget's brilliant pupilage at the Hospital, in prizes, was the cause of his success. I entered the Hospital the same year as Alfred "Catt," who soon changed his name to "Willett," and I was house-surgeon with him. Then I joined my father and uncle in practice at Hampstead; my uncle, "William Haines," soon retired and went to Australia, and was Colonial Secretary at Melbourne for some years. Arthur Evans, also at Bartholomew's, was appointed a surgeon to the East India Co., and went out with his bride to Calcutta, where a cyclone arose—all were drowned. "William Lawrence" was senior surgeon and used to operate when he was over 80. Skey, who was a pupil of "Abernethy," was chiefly instrumental in the rule that 65 should be the age of retiring. After taking my degree at Oxford I entered the College at Bart.'s, living just opposite, in Duke Street, at a public-house kept by an old prize-fighter, "Peter Crawley," who afterwards had an apoplectic attack, and came to the Hospital as a patient and was bled by Dr. "Andrew," Wadham Col.

I came home from Winchester with typhoid fever—it was then called low fever or continued fever, in contra-distinction to scarlet and intermittent. I can just recollect being placed on the first water-bed. It was a mahogany bedstead lined with sheet lead, like a bath, and cans of warm water were poured into it. It was known as Dr. "Arnott's" water-bed, and I well recollect he used to come round with Stanley when I was house-surgeon. I was at Winchester with "Pridgeon Teale," of Leeds, the rectangular flap inventor.

Please excuse this long ramble of a *Tum boyerau*.

HERBERT N. EVANS.

IODIDES.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—I have just been reading "Humour and the Consultant" in this month's Bart.'s JOURNAL, and think perhaps the following story may amuse some of your readers. It is an absolutely true story, the incident occurring this week.

Dr. A— took a Mrs. W—, who was suffering from osteitis deformans together with valvular disease of the heart and an aortic aneurysm, to see Mr. C—, a consultant. After carefully examining the patient and looking at the X-ray photographs he told the patient that although he did not think it was possible to cure her condition, still he thought the pains could be relieved and that he would have a talk with Dr. A— as to treatment. He told Dr. A— that he was of the opinion that there was a syphilitic element in the case, and he would advise large doses of IODIDE.

The next day the consultant received the following letter from Dr. A—: "Dear Mr. C—,—With reference to Mrs. W— and IODIDES, you were quite right about the pains stopping, but it was not the 'I-who-dide' but the 'she-who-dide' (last night) that unfortunately did the trick."

—, F.R.C.S.Eng.

REVIEWS.

A SHORT PRACTICE OF MIDWIFERY. By HENRY JELLETT, M.D., F.R.C.P.I. 9th Edition; revised. (J. & A. Churchill, 1924.) Price 18s.

The appearance of a ninth edition of this work of Dr. Jellett will be universally welcomed, for it has a great reputation as a text-book of midwifery. Dr. Jellett is a master of lucidity, and by displaying

the dogmatism necessary for a good teacher, he reduces intricate and sometimes obscure problems to simplicity. The additions to the new edition bring the book well up to date in certain fields, but more attention could have been paid to routine ante-natal examination and to puerperal sepsis. The author's well-known views on the operation of pubiotomy are mentioned, with the requisite indication that they are not universally accepted. There is a healthy criticism of what the author terms "meddlesome midwifery," which should be assimilated by all. The standard of the diagrams and of the print remains high, and it is undoubtedly true that no better elementary text-book of obstetrics in the English tongue exists than this work.

PRACTICAL SURGERY, ILLUSTRATED. By VICTOR PAUCHET. Illustrated by F. B. R. ATKINSON, M.B., C.M. With Introduction by Sir CHARLES GORDON-WATSON, C.M.G., F.R.C.S. (Ernest Benn, Ltd., 8, Bouvierie Street, E.C. 4.) Vols. III, IV, V and VI.

We have already reviewed volumes I and II. These latter volumes continue much on the same lines, being profusely illustrated, both with drawings of actual operations and diagrams illustrating various procedures adopted by the surgeon. The almost universal adoption of local, spinal and splanchnic anaesthesia is a very prominent feature in the practice of the surgeon. One readily gathers the impression that abdominal surgery is the chief forte of the author, although scattered about these books are to be found procedures adopted in connection with the breast, prostate, oesophagus, bones, etc. Some of these are dealt with by colleagues. It is a little troublesome that the various abdominal conditions which are described are not all placed together, for even the methods adopted in the surgical treatment of a single viscus—for example, the duodenum—are to be found in each of the volumes. The literature contains a good deal of useful information with regard to the methods used, but by far the most valuable portions of the book are the illustrations with their diagrammatic drawings. It can safely be said that the book will have a stimulating effect on those anxious to try the most efficacious and up-to-date methods of treatment and should be useful to all young surgeons.

THE NURSES' HANDBOOK OF HYGIENE. By L. E. H. WHITBY, B.A., M.B., B.Ch., D.P.H. (London : The Scientific Press, Ltd.) Price 4s. 6d. net.

In the attempt to make a small volume the author has failed to give the student the practical help which is all that is needed by a nurse in house-to-house visiting, though he has given, in some cases, too much information of a technical character, which few nurses have time to study. It is doubtful if oil of peppermint introduced into a drainage system in the manner explained on p. 49 would prove a satisfactory test.

SOME ENCOURAGEMENTS IN CANCER SURGERY. By G. GREY TURNER, F.R.C.S. (John Wright & Sons, Ltd.) Pp. 74. Price 7s. 6d.

This little book contains the substance of a demonstration given before the Surgical Section of the Royal Society of Medicine.

The author is in favour of bold surgery in cases of malignant growths, and the cases which he quotes show that in his hands this attitude is certainly justified.

The book is excellently illustrated by forty figures. It should prove interesting to the younger surgeons, to whom its message is address—interesting perhaps rather than useful.

LECTURES TO NURSES. By MARGARET S. RIDDELL, A.R.R.C. New and Enlarged Edition. (London : The Scientific Press, Ltd.) Price 6s. net.

This manual, although useful in the main, is somewhat old-fashioned. In the treatment of meningitis (p. 191) blistering the neck is mentioned, but not lumbar puncture. The nursing directions for encephalitis, a disease in which much nursing may be required, are very inadequate. On p. 271 it states "the injection hypodermically of morphine is 2 to 5 minims ($\frac{1}{2}$ — $\frac{1}{4}$)," which is obviously incorrect. In the section on obstetrical nursing no directions are given as to the fate of the baby; it is "wrapped in a warm blanket and put in a safe place while the mother is attended to." On p. 234 is a printer's error—N.R.B. instead of N.A.B. Except for these minor points it is a book of moderate price, which should be useful to nurses in training.

GYNAECOLOGY FOR NURSES. By COMYN BERKELEY. (London : The Scientific Press, Ltd.)

This edition is a great improvement on what was already a very useful book for nurses. It now contains all the information required for the gynaecological section of the State Examination as well as that required by a nurse engaged in private nursing.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

- ADAMS, WILMOT, F.R.C.S. "Two Cases of Foreign Bodies in the Gastro-intestinal Tract." *British Journal of Surgery*, July, 1925.
- BEYERS, C. F., B.A., M.B., B.S., F.R.C.S. "Normal and Abnormal Negroid Septa Pellucida." *Journal of Anatomy*, July, 1925.
- BOWLBY, Sir ANTHONY, Bart., K.C.B., K.C.M.G., K.C.V.O., F.R.C.S. "Introduction to Atlas of Pathological Anatomy." *British Journal of Surgery*, July, 1925.
- BROUGHTON-ALCOCK, W., M.B. (and DOUGLAS MACKENZIE, M.D., and H. C. LUCEY, M.D.), "A Study of the Tubercle Complement-Fixation Reaction with Besredka Antigen in the Investigation of Pulmonary Diseases." *Lancet*, June 27th, 1925.
- BROWN, W. LANGDON, M.A., M.D., F.R.C.P. Discussion on the Treatment of Asthma. *British Medical Journal*, August 29th, 1925.
- CAMMIDGE, P. J., M.D., M.R.C.S., L.R.C.P. "The Dosage of Insulin." *Practitioner*, September, 1925.
- CHANDLER, F. G., M.A., M.D., M.R.C.P. "Pulmonary Tuberculosis in Childhood." *British Journal of Children's Diseases*, January-March, 1925.
- "An Improved Refill Needle for Artificial Pneumothorax." *Lancet*, August 22nd, 1925.
- "Types of Empyema." *British Medical Journal*, August 22nd, 1925.
- CLARKE, W. E. LE GROS, F.R.C.S. "The Visual Cortex of Primates." *Journal of Anatomy*, July, 1925.
- COLT, G. H., F.R.C.S. "Three Cases of Aneurysm of the Aorta Treated by Wiring: I. Aneurysms of the Abdominal Aorta." *British Journal of Surgery*, July, 1925.
- CUMBERBATCH, E. P., B.M., B.Ch., M.R.C.P. "Treatment of Gonococcal Infection by Diathermy." *Proceedings of the Royal Society of Medicine*, July, 1925.
- DAVIES, IVOR J., M.D., M.R.C.P. "Progressive Muscular Atrophy." *Clinical Journal*, September 9th, 1925.
- DUNHILL, T. P., C.M.G., M.D., Ch.B. "The Surgical Treatment of Exophthalmic Goitre: Part I.—The Decision to Operate." *Lancet*, September 19th, 1925.
- "The Surgical Treatment of Exophthalmic Goitre: Part II.—The Operation and its Danger." *Ibid.*, September 26th, 1925.
- FISHER, A. G. TIMBRELL, M.C., F.R.C.S. "Principles of Treatment by Manipulation of Some Chronic Disorders of the Knee-joint following Injury." *Lancet*, September 12th, 1925.
- GASK, GEORGE E., C.M.G., D.S.O., F.R.C.S. "The General Surgical Standpoint." *British Medical Journal*, August 22nd, 1925.
- GORDON, M. H., C.M.G., M.D., F.R.S. "Viruses of Vaccinia and Variola." *Ibid.*, August 1st, 1925.
- GORDON-WATSON, Sir CHARLES, K.B.E., C.M.G., F.R.C.S. Discussion on the Prevention and Treatment of Post-operative Pulmonary Affections. *Proceedings of the Royal Society of Medicine*, July, 1925.
- HADFIELD, C. F., M.D. Discussion on the Prevention and Treatment of Post-operative Pulmonary Affections. *Ibid.*, July, 1925.
- HEY GROVES, ERNEST W., B.Sc., M.D., M.S., F.R.C.S. "Fracture Dislocation of the Upper End of the Humerus." *Lancet*, September 5th, 1925.
- LANE-ROBERTS, C. S., M.S., F.R.C.S. "Venereal Disease in Pregnancy." *Clinical Journal*, August 12th, 1925.
- LEVICK, G. MURRAY, M.R.C.S. "Successful Researches in the Treatment of Infantile Paralysis." *Lancet*, August 15th, 1925.
- MOORE, R. FOSTER, O.B.E., F.R.C.S. *Medical Ophthalmology*, 2nd Edition. London : J. & A. Churchill.
- MYERS, BERNARD, C.M.G., M.D., M.R.C.P. "The Nervous Child as seen in Medical Practice." *British Medical Journal*, July 25th, 1925.
- NEWMAN, Sir GEORGE, K.C.B., M.D., F.R.C.P. "Fifty Years of Progress in Public Health." *Lancet*, July 25th, 1925.

- PATERSON, HERBERT J., C.B.E., M.C., F.R.C.S. "Treatment of Patients Before and After Abdominal Operations." *Practitioner*, August, 1925.
- POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Eponyms: Charcot's Joints." *British Journal of Surgery*, July, 1925.
- RIVIERE, CLIVE, M.D., F.R.C.P. "Tuberculosis in Childhood." *Medical Officer*, July 25th, 1925.
- ROBINSON, C. A., B.A., M.B., D.M.R.E. "Technique Used in the Treatment of Gonorrhoeal Infections by Diathermy." *Proceedings of the Royal Society of Medicine*, July, 1925.
- SHAW, ERNEST H., M.R.C.P. "Carcinoma of the Vermiform Appendix." *British Journal of Surgery*, July, 1925.
- SPICER, W. T. HOLMES, F.R.C.S. Discussion on Eye Injuries and Interstitial Keratitis. *British Medical Journal*, August 29th, 1925.
- STRETTON, J. LIONEL, M.R.C.S. "The Ultimate Fate of Disused Portions of Intestine after Complete Short-circuiting Operations." *Practitioner*, September, 1925.
- TEICHMANN, O., D.S.O., M.C., R.A.M.C.(T.A.). "Surgeon-Major Belloste." *Journal Royal Army Medical Corps*, September, 1925.
- WARD, R. OGIER, M.Ch., F.R.C.S. "A Clinical Study of Eleven Cases of Vesical Diverticula." *British Journal of Surgery*, July, 1925.
- WATKYN-THOMAS, F. W., F.R.C.S. "Sequestra of Labyrinth." *Proceedings of the Royal Society of Medicine*, July, 1925.
- WILLIAMS, R. LESTER, M.B., B.Ch., F.R.C.S. "A Case of Acute Intestinal Obstruction due to the Presence of a Drainage-tube Left in the Peritoneal Cavity." *Lancet*, August 1st, 1925.
- YATES, A. LOWNDES, M.D., F.R.C.S.(Edin.). "The Nasal Sinuses as a Route of Infection in Encephalitis Lethargica." *Ibid.* July 18th, 1925.

CHANGES OF ADDRESS.

- INGER, W. B., 7, Cadogan Place, S.W. 1. (Tel. Sloane 2658.)
 ANDREWES, C. H., Windy Gap, Merton Lane, Highgate, N. 6.
 COLDREY, E. A., Chatham House, Rotherham, Yorks.
 ELWORTHY, H. S., 7, Devon Avenue, Greve D'Azette, Jersey, C.I.
 GOODWIN, T. S., C.M.S. Hospital, Kienning, Fukien, S. China, via Siberia.
 HERINGTON, C. E. E., Public Health Office, Doncaster.
 HORNER, N. G., 3, Smith Street, Chelsea, S.W. 3. (Tel. Sloane 3617.)
 HUME, J. B., 3, Handel Mansions, Brunswick Square, W.C. 1.
 KYNASTON, A. H., 62, Narbonne Avenue, Clapham, S.W. 4.
 LORENZEN, A. E., c/o Director, Sudan Medical Service, Khartoum.
 PROSSER, T. G., Caldecote, near Market Harborough.
 SMITH, A. B. PAVEY, Portland House, 14, Leeds Road, Harrogate. (Tel. Harrogate 379.)
 TAIT, H. B., Ashmount, 68, Richmond Road, Worthing, Sussex.
 TREWBY, J. F., 55A, Welbeck Street, W. 1. (Tel. Langham 2310.)
 WILKINSON, W., c/o P.M.O., Kenya Colony, E. Africa.

APPOINTMENTS.

- HERINGTON, C. E., M.B., B.S.(Lond.), D.P.H., R.C.P.S., appointed Assistant Medical Officer of Health and Assistant School Medical Officer to the Borough of Doncaster.
- ROBINSON, V. P., B.M., B.Ch.(Oxon.), appointed House Physician to the Royal Infirmary, Sunderland.
- ROBINSON, W. V., B.M., B.Ch.(Oxon.), appointed Honorary Anaesthetist to the Sunderland Royal Infirmary.

BIRTHS.

- BROWN.—On August 19th, at Bassett Crescent, Southampton, the wife of Dr. A. W. Brown, of a daughter.
- CROSSMAN.—On September 16th, to Dr. and Mrs. Francis Ward Crossman, Whites Hill, Hambrook, Glos.—a son.
- ELGOOD.—On August 28th, at 20, Colebrooke Road, Bexhill-on-Sea, to Ethel, wife of Dr. C. Elgood—a son.
- GRIFFITH-JONES.—On July 24th, at Brooklyn, Wellingborough, to Dorothy, wife of C. Griffith-Jones—a daughter.
- HALES.—On September 12th, at Lees Lodge, Sheringham, Norfolk, to Pearl (nee Lee-Elliott), wife of Henry Ward Hales, M.D.—a daughter.
- HEPPER.—On August 7th, at Frimley, Surrey, to Rosalind, wife of Dr. John E. Hepper—a son.

- NIXON.—On July 25th, at 7, Lansdown Place, Clifton, to Doreen G. C. Nixon, M.R.C.S., L.R.C.P., wife of Dr. J. A. Nixon, a son (Gervase John Mapleton), who only lived an hour, and a daughter SATOW.—On July 26th, at "Ackland," Oxford, the wife of Lawrence L. Satow, M.C., M.R.C.S., etc., of a son.

MARRIAGES.

- ADENEY—WARDLE.—On July 23rd, at St. Botolph's, Aspley Guise, Noel Frederick Adeney, F.R.C.S., to Bettie Holborn Gray, daughter of G. I. Wardle, of Ilford, Essex.
- BROWN—WRIGHT.—On September 15th, at St. Paul's, Cambridge, Alexander Carnegie Brown, elder son of Rev. and Mrs. J. Carnegie Brown, to Ella Mary Wright, younger daughter of Mr. and Mrs. Arthur Wright.

- COLDREY—GARDINER.—On September 16th, at Camborne, Eric Arthur Coldrey, M.D.(Lond.), younger son of Mr. and Mrs. A. A. Coldrey, The Laurels, Purley, Surrey, to Eleanor Isabella, only daughter of Peter Gardiner, M.D., and Mrs. Gardiner, Roslyn, Camborne, Cornwall.

- HOSFORD—RANDALL.—On September 8th, at All Saints' Church, Ryde, by the Rev. Hugh le Fleming, Reginald Walter Patrick Hosford, M.B., F.R.C.S., eldest son of Dr. and Mrs. Hosford, of Hornsey Lane, Highgate, to Nora Kathleen, daughter of Mr. and Mrs. F. W. Randall, of Mayfield, Ryde.

- HUME—POOLE.—On September 3rd, at Westcliff-on-Sea, John Basil Hume, F.R.C.S., son of Mr. and Mrs. David Hume, of Whitby, to Marjorie Constance, younger daughter of Mr. and Mrs. Frederick Poole, of Westcliff.

- LONGFORD—DUNN.—On August 4th, at High Street Presbyterian Church, Holywood, by the Rev. D. H. Macdonochie, B.A., B.D., assisted by the Rev. John H. Irrath, B.A., William Ulric Desmond Longford, only son of Mr. and Mrs. William Longford, of Milan, Italy, to Elizabeth Jane Dalzell, elder daughter of Mr. and Mrs. William Dunn, Kinnegar, Holywood, co. Down, Ireland.

- PARRISH—WHITEHEAD.—On August 14th, at St. Bartholomew-the-Great, John, son of Mr. and Mrs. J. Parrish, of Woodlands, Romford, Essex, to Ethel Maude, eldest daughter of Col. and Mrs. Whitehead, "Shuna," West Byfleet.

- POTTS—HEPWORTH.—On July 30th, at Brompton Parish Church, South Kensington, by the Rev. Prebendary Gough, M.A., Dr. John Leonard Potts, only son of Mr. and Mrs. Leonard Francis Potts, of Ealing, to Nancy May, younger daughter of Mr. and Mrs. Allan Hepworth, of Ealing.

- SHORE—HOARE.—On September 12th, at St. Bartholomew-the-Great, Smithfield, by the Rev. P. F. J. Burgess, Vicar of West Harptree, Bristol, assisted by the Rev. Tilden Smith, M.A., Thomas Henry Gostwyck, M.D., M.R.C.P., elder son of Thomas William Shore, O.E.E., M.D., of St. Bartholomew's Hospital, to Viola Edith, second daughter of the late Frederick Hoare, Esq., of Craiglands, Crouch End Hill, and Mrs. Hoare, 44, Stanhope Gardens, Highgate, N. 6.

- SIMPSON—BATTEN.—On August 5th, at St. Mary Abbot's, Kensington, by the Rev. H. J. Matthews, Reginald Hugh Simpson, M.B., M.R.C.P., elder son of the late Frank Moncreiff Simpson, to Joyce Rayner Batten, M.B., B.Ch., younger daughter of Dr. and Mrs. Rayner Batten, of Campden Lodge, W.

DEATHS.

- NICHOLLS.—On July 1st, 1925, at Longton, Staffs, Hubert Nicholls, M.D.(Cantab.).

- WILLIAMS.—On July 16th, 1925, Dr. John Terrell Williams, of 262, Abbey Road, Barrow, aged 80.

NOTICE.

All communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, ST. BARTHOLOMEW'S HOSPITAL, SMITHFIELD, E.C. 1.

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All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, THE JOURNAL OFFICE, ST. BARTHOLOMEW'S HOSPITAL, E.C. Telephone: CITY 510.